Claims Clues

A Publication of the AHCCCS Claims Department June, 2003

AHCCCS Recoups Payment from Providers If Medicare Posted Retroactively for Recipient

Occasionally, AHCCCS learns that a member is eligible for Medicare after payment has been made to the provider.

When that happens, AHCCCS recoups the money overpaid from future payments to the provider and advises the provider to bill Medicare.

AHCCCS has established an automated crossover process for fee-for-service claims from providers whose Medicare carrier or intermediary is BlueCross/ BlueShield of North Dakota (Noridian), BlueCross/BlueShield of Arizona, and BlueCross/ BlueShield of Texas (TrailBlazer Health Enterprises). When payment from Medicare is made, the Medicare intermediary or carrier should cross the claim over to AHCCCS for correct payment of any member liability, usually deductible and/or coinsurance. If the crossover does not occur, the provider should submit a claim to AHCCCS with the Explanation of Medicare Benefits (EOMB).

AHCCCS has always handled claims in this fashion when the agency became aware that a member has Medicare. AHCCCS also has contracted with Public Consulting Group, Inc. (See article below) to identify inpatient hospital claims that are overpaid due to the late posting of Medicare eligibility.

Recently, AHCCCS has begun to systematically identify all members with retroactive Medicare posting for whom the agency has paid claims from both hospitals and other providers, without consideration of the potential Medicare payment. A report is reviewed monthly and allows AHCCCS to recoup any overpayments from all provider types.

When AHCCCS recoups, providers should bill Medicare and follow the procedure outlined in paragraph three to ensure timely and accurate payment. ❒

TPL Contractor Helps AHCCCS Recover Payments

Public Consulting Group, Inc. (PCG), a national consulting firm headquartered in Boston, is the official AHCCCS Third Party Liability (TPL) contractor.

Providers may find themselves working with PCG, for instance, if an AHCCCS member is involved in an auto accident in which another insured party was at fault. Arizona law allows the state to recover AHCCCS expenditures from other liable third parties who are at fault, in order to help fund the program. PCG has served the state since 1998 and was recently re-awarded another contract in March in a competitive bidding process.

PCG helps AHCCCS perform all TPL services, including recoveries from casualty, estates, trusts, restitution, Medicare, commercial insurance and CHAMPUS.

All potential casualty cases should be referred to PCG to determine if the case involves any AHCCCS expenditures (fee-for-service or reinsurance). PCG will then enter the case into a Web-based Case Management Tracking System (CMTS®) database for tracking and recovery. If AHCCCS has incurred expenses, PCG will manage the case, determine the lien amount, and file a lien representing both the health plans' and AHCCCS' interest. This activity also requires that all health plans and other providers cooperate with the state.

Providers may visit the PCG Website at www.PCGus.com, or contact them at:

Public Consulting Group, Inc.
Attn: Catherine Cox
1653 Mahan Center Boulevard
Tallahassee, FL 32308

Phone: (888) 378-2836

E-mail: CCox@PCGus.com ❒

Medifax to Display Messages Advising Providers If Recipient's Record Has Primary or Secondary ID

Effective July 1, Medifax will display warning messages to advise providers that the recipient eligibility record that they are attempting to verify has a primary ID or a secondary ID.

Medifax previously did not provide any information on secondary records other than returning the primary AHCCCS ID number for the recipient. The change has been made to display verification information when the provider enters the recipient's secondary ID.

AHCCCS receives member demographics from several eligibility sources, and members do not always provide consistent information. When transactions are received from the eligibility source, every effort is made to match the member with an existing recipient record. Sometimes, however, a second record is created. When multiple records are identified, the records are linked together creating primary and secondary IDs.

When a provider enters a secondary ID, the following message is displayed:

"Warning Information: The AHCCCS ID entered is a Secondary AHCCCS ID. Correct AHCCCS ID is: #########." Medifax will then furnish the requested information on the secondary ID record.

When a provider enters a primary ID for a recipient with a linked secondary ID, the following message is displayed:

"Warning Information: The AHCCCS ID entered has a Linked Secondary AHCCCS ID: ######### " Medifax will then furnish the requested information.

If the health plan on the primary ID record indicates fee-for-service status (e.g., 008690, FFS Temporary) but the secondary ID indicates enrollment in a health plan, the primary record will display the word "Second" in place of the fee-for-service plan number. Medifax will advise the provider to "Check secondary for enrollment." ❒

Open Enrollment Likely to Tax Comm Center Phones; Providers Should Use Other Verification Processes

During the next few months, some 125,000 AHCCCS members will be selecting new health plans, and the Communications Center phones are expected to be very busy during this time period.

AHCCCS recently awarded contracts to seven acute care health plans, effective October 1. Members of plans that will not continue with AHCCCS or that did not receive contracts to serve in their current areas will have the opportunity to select new plans before October 1. The changes will affect more than 125,000 AHCCCS members who will have to select new plans.

Effective July 1, the Communications Center's business hours will be from 6 a.m. through midnight. Verifications

and newborn notifications will be taken by Comm Center staff during those hours.

All automated verifications systems (Medifax, IVR, and the Web) will be available 24 hours a day.

The enrollment process is expected to generate a high volume of telephone calls to the Communications Center, making it difficult for providers to obtain member eligibility and enrollment information from Communications Center staff.

Providers who need to verify the eligibility and enrollment of an AHCCCS member should use one of the alternative verification processes during this period. These processes include:

- Interactive Voice Response system (IVR)

IVR allows unlimited verifications by entering information on a touch-tone telephone.

Providers may call IVR at:

Phoenix: (602) 417-7200

All others: 1-800-331-5090

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Open Enrollment Likely to Tax Comm Center Phones; Providers Should Use Other Verification Processes

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- Medical Electronic Verification System (MEVS)

MEVS uses "swipe card" technology to verify eligibility and enrollment.

For information on MEVS, contact one of the MEVS vendors:

Envoy: 1-800-366-5716

Potomac Group: 1-800-444-4336

- Eligibility Verification System (EVS)

EVS, also known as Medifax, allows providers to use a PC or terminal to access eligibility and enrollment information.

For information on EVS, contact the Potomac Group at 1-800-444-4336

- Internet

AHCCCS has developed a Web application that allows providers to verify eligibility and enrollment using the Internet.

To create an account and begin using the application, go to the AHCCCS Home Page at www.ahcccs.state.az.us. Click on the Information for Providers link to go to the Providers page. A link on the Providers page allows providers to create an account. ❒

AHCCCS to Accept Excluded Pathologists Claims

In response to a court order, the AHCCCS Administration will accept submissions of certain **fee-for-service** claims from pathologists that were excluded from payment for their use of the 26 modifier (Professional component) on claims for laboratory services.

Fee-for-service claims for inpatient lab services billed by pathologists with dates of service from June 1, 1999 through April 7, 2003 must be submitted to the AHCCCS Claims Department by October 7, 2003. Pathologists may continue to submit these old claims, despite the normal six-month limit on initial submissions.

In addition, pathologists may submit timely **fee-for-service** claims (with initial submission dates within six months of the date of service) until the Administration adopts a rule limiting these services.

The claims will receive special handling, and timeliness edits will be overridden if necessary.

Claims should be submitted to:

AHCCCS Claims
Attn: Diane Sanders
Claims Administrator
Mail Drop 8200
P.O. Box 1700
Phoenix, AZ 85002-1700

Please mark the envelope with the words "Pathology Claims."

Claims for members enrolled in a health plan still must be sent to the appropriate health plan for consideration. ❒

Claims Without Provider ID Cannot Be Adjudicated

Fee-for-service claims submitted to the AHCCCS Administration without an AHCCCS provider ID number cannot be adjudicated, and the provider must resubmit the claim with the provider ID in the appropriate field.

When a claim is received without a provider ID number, the AHCCCS Claims Department sends a Missing Provider ID letter to the provider identified on the claim. The letter is sent to the address listed in Field 33 of the CMS 1500 claim form or Field 1 of the UB-92 claim form.

The letter advises the provider to resubmit the claim with the AHCCCS provider ID in the appropriate field. Providers who do not have an AHCCCS ID are advised to contact the Provider Registration Unit. ❒

AHCCCS to End Coverage of Codes D1310, D1330

Effective July 1, AHCCCS will no longer separately reimburse dental providers for codes D1310 (Nutritional counseling for control of dental disease) and D1330 (Oral hygiene instructions).

Discussion of general nutrition and oral hygiene instruction is considered included, and should be reported as, part of routine dental exams.

AHCCCS also has re-opened CDT-3 codes that had been closed effective April 1, 2003. Codes that were deleted in the CDT-4 Manual will be kept open until September 30. ❒

Electronic Claims Process Enhanced to Provide Acknowledgement of Receipt of Transmission

The AHCCCS Administration has enhanced the electronic claims submission (ECS) process to acknowledge receipt of electronic claims transmissions to AHCCCS.

Providers and vendors who have been submitting claims electronically have requested this enhancement for some time.

AHCCCS now sends a response file that acknowledges receipt of the provider/vendor's electronic claims transmission. The provider/vendor must check their ECS outbox to view the responses for file acceptance or the reasons for file failure.

ECS is the quickest way for providers to be reimbursed. This applies even to claims requiring documentation. These claims are reviewed in claim number order based on the original receipt date, once the documentation is received and linked to the initial claim submitted.

AHCCCS accepts electronic claims transmissions between midnight and 6:00 p.m. Monday through Thursday and between midnight and 4:00 p.m. on Fridays.

Clean claims on completed transmissions received by 4:00 p.m. on Friday generally will be considered for that weekend's payment cycle. The electronic claims process typically results in a faster turnaround of reimbursement to the provider.

For more information on electronic claims submission, contact the AHCCCS ECS Unit at (602) 417-4706. ❐

Admission Fields on UB-92 Must Have Valid Values

Invalid values entered in three consecutive fields of the UB-92 claim form are causing some fee-for-service claims to be denied while others are being reimbursed incorrectly.

UB-92 billers should ensure that valid values are entered in the following fields:

- Field 18 – Admission Hour
  Valid values are 00 through 23. Providers should not enter times using a.m. or p.m., such as "3 a.m." or "3 a."
- Field 19 – Admission Type
  Valid values are 1 though 5. Providers should not enter a zero (Ø) in this field. The field may be left blank.
- Field 20 – Admission Source
  Valid values are 1 through 8. Providers should not enter a zero (Ø) in this field. The field may be left blank.

Please consult the UB-92 Manual for definitions of these values and additional information. ❐

AHCCCS Acute Care Health Plans Effective October 1, 2003

GSA	Counties	Health Plans
GSA 2	Yuma, La Paz	APIPA, Mercy Care Plan
GSA 4	Apache, Coconino, Mohave, Navajo	APIPA, Health Choice Arizona
GSA 6	Yavapai	APIPA, Mercy Care Plan
GSA 8	Gila, Pinal	Health Choice Arizona, Phoenix Health Plan/ Community Connection
GSA 10	Pima, Santa Cruz	APIPA, Pima Health Plan, Health Choice Arizona (Pima only), Mercy Care Plan (Pima Only)
GSA 12	Maricopa	APIPA, Care 1st, Health Choice Arizona, Maricopa Health Plan, Mercy Care Plan, Phoenix Health Plan/ Community Connection
GSA 14	Cochise, Graham, Greenlee	APIPA, Mercy Care Plan